

Magellan Behavioral Health CSA Staff

January 10, 2014



Introductions

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Magellan Company Overview

Magellan Health Services: Building for the Future

As the nation's leading specialty health care management company, we care for populations that require the most specialized support and provide clients with peace of mind as we work to improve health and reduce costs.

Behavioral Health Solutions

- Behavioral health for special populations
- Integrated medical and behavioral care
- Enhanced technology capabilities
- Ongoing Autism product expansion

Serving 33.8 million lives

Medical Specialty Solutions

- Management of new medical technologies
- Management of radiology benefits for special populations
- Pain management product and expanded cardiac product

Serving 17.2 million lives

Pharmacy Solutions (ICORE & MMA)

- Total drug management
- Pharmacy benefit management for special populations
- Medicaid MCO product expansion
- Medical pharmacy enhancements

Serving 7.8 million lives

Magellan Fast Facts

- \$3.2B annual revenue
- Nearly 5,000 employees
- Multiple accreditations (NCQA, URAC, COA)
- Serving over 58 million lives
- Serve Medicaid members including Seriously Mentally Ill (SMI), with a whole-health solution in FL
- Partner with health plans, employers, state/local and federal governments and the military

Behavioral Health & System of Care Solutions

- **4.2 million Medicaid lives nationally through direct State contracts and health plans**
- 15 Direct Contracts in 7 States covering 3M Lives (not including VA)
- More than **18 years of experience** managing **behavioral health** for adults and children through **Medicaid**; we understand the **unique challenges** of working in a **public health care system** and offer **quality-driven solutions**
- We have **transformed systems** from block granted and/or FFS systems to managed models in IA, PA, FL, and most recently LA state-wide
- **Savings** for the behavioral and medical care for Medicaid members **occur as a result of our focus on assisting providers to provide more efficient care and empowering individuals to monitor and improve their own health through self-management tools and resources** including peer support

Why Magellan as the BHSA?

- **Long-standing presence** in Virginia and the existing work with DMAS.
- Demonstrated commitment to working with **all** community stakeholders.
- **Specialized knowledge** of both traditional and non-traditional services and the needs of special populations.
- Focus on **quality, performance and outcomes**.
- Optional services that include innovation in **Learning Collaboratives** and **peer-delivered** services.

Overall Approach to the BHSA

Transparency, Inclusion, Value

Purpose

- Magellan works with DMAS to improve access to quality behavioral health services and improve the value of behavioral health services purchased by the Commonwealth. Magellan administers a comprehensive care coordination model which is expected to reduce unnecessary expenditures
- Comprehensive care coordination including coordination with DMAS Managed Care Organizations. Magellan has hired a dedicated MCO Liaison to collaborate with MCOs.
- Promotion of more efficient utilization of services
- Development and monitoring of progress towards outcome-based quality measures

Purpose

- Management of a centralized call center to provide eligibility, benefits, referral and appeal information
- Provider recruitment, issue resolution, network management, and training
- Utilization management of behavioral health services
- Quality Assurance, Improvement and Outcomes program
- Service authorization
- Member outreach, education and issue resolution
- Claims processing and reimbursement of behavioral health services that are currently carved out of managed care

Understanding of the 18 Principles: 2011, 2012 and 2013 Acts of Assembly

1. Improves value so that there is better access to care while improving equity.
2. Engages consumers as informed and responsible partners from enrollment to care delivery.
3. Provides consumer protections with respect to choice of providers and plans of care.
4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.
5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.
6. Improves quality, individual safety, health outcomes, and efficiency.
7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.
8. Builds upon current best practices in the delivery of behavioral health services.
9. Accounts for local circumstances and reflects familiarity with the community where services are provided.
10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.
11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.
12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.
13. Promotes availability of access to vital supports such as housing and supported employment.
14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.
15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.
16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.
17. Provides actionable data and feedback to providers.
18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

Population & Services to be Managed and Coordinated

- Magellan manages the full spectrum of **behavioral health services** for:
 - Medicaid and FAMIS members, including members who participate in Medicaid home and community based waiver programs, such as the Intellectual Disabilities Waiver, Elderly and Disabled with Consumer Direction Waiver, and Individual and Family Developmental Disabilities Support Waiver.
 - members who are not currently enrolled in one of the DMAS managed care organization(MCO) contracts.
 - the subset of community mental health and rehabilitation services that are excluded from the DMAS MCO contracts.
- Magellan will NOT manage traditional behavioral health inpatient and outpatient services (such as psychotherapy) for members in DMAS managed care organization(MCO) contracts.

BHSA Program: What is the same

- Regulations, manuals, licensing, covered services and service descriptions
- Eligible members – Medicaid, FAMIS
- Eligibility determination and process remains the same
- Rates, procedure codes
- Service limitations remain the same
- Services requiring authorization will continue to require authorization
- Any changes to the VICAP process, to rates, or to anything else will be announced via memos and communications in the future.

Covered Services

Community Mental Health Rehabilitative Services (CMHRS) such as:

- Intensive In Home
- Therapeutic Day Treatment
- Mental Health Support
- Psychosocial Rehabilitation
- Intensive Community Treatment

Inpatient and Outpatient Psychiatric and Substance Abuse Treatment Services such as medication management, and individual, family, and group therapies for non-MCO enrolled members.

MH/SA Targeted Case Management and Treatment Foster Care Case Management

Residential Treatment (Levels A, B & C)

EPSDT Behavioral Therapy

Substance Abuse Services

BHSA Program : What is different for Members & the Community At-Large

- A Shared-Governance Board is being created to assure the voice and participation of community stakeholders in the BHSA program
- Members, providers and other involved parties have access to the toll-free line to inquire about Medicaid behavioral health network providers, coordinate care for DMAS covered services and MCOs/other payers and to discuss care issues as needed
- Members, providers and other involved parties have access to on-line tools and resources to improve health and wellness
- Magellan provides authorizations (not KePRO)
- Magellan performs Utilization Management & Care Coordination to “shape” and improve quality of care, emphasizing evidence-based practices
- Magellan engages in Quality Assurance & Quality Improvement efforts

BHSA Program : What is different for providers

- Credentialing- is NCQA compliant
- Magellan platforms claims payment- multiple claims submission methods
- Magellan of VA website is a source of information, training claims submission and program updates
- Local provider relations team dedicated to supporting the BHSA program, provide technical assistance and problem resolution
- Provider Forums were conducted across Virginia in September. Additional trainings and webinars occurred in November to provide training and technical assistance to providers. Email blasts are also being used to disseminate information.
- Free CEU's

Community Governance Board: Assuring the Voice & Participation of Members & Stakeholders

- Designed to promote transparency, accountability, and collaboration
- Creation of a Governance Board to include the voice and participation of all stakeholders and assure that the implementation and operation of the program is responsive to local needs
- Stakeholder representation on the Board includes members, persons in recovery, parents or custodians of children and adolescents, CSBs, private community providers, advocates, and health plan/community health representatives
- **Magellan's shared governance structure is inclusive.**

Community Representation	Magellan Representation
CSB or CSB Association Representative	Project Director
Private Community Provider or Association Representative	Provider Relations Director
Adult Service Member Representative	Medical Director
Parent or Custodian Representative of a Child or Adolescent Member	QM/UM Director
Advocate for Mental Health	Director of Recovery and Resiliency
Advocate for Substance Abuse Services	Member Services Director
Health Plan /Community Health Representative	MCO Liaison

Services and Other Limits

- Based on Virginia Administrative Code, CMHRS Manual, EPSDT Manual, and Psychiatric Services Manual
- Most services have annual limits
- VICAP required for Intensive In-Home Services, Therapeutic Day Treatment, and Mental Health Skill-Building Services

Services Requiring Authorizations

- Inpatient psychiatric
- CMHR Services-IIH, TDT, MHSS, Day Treatment/Partial, ICT, PSR
- Outpatient psychiatric and substance abuse
- Level A, B, and C Residential
- Treatment Foster Care Case Management
- EPSDT Behavioral Therapy
- For additional information about authorizations for services:
www.MagellanofVirginia.com or
VAProviderQuestions@MagellanHealth.com

Overview of Medical Necessity

- Used for services requiring authorization
- Medical necessity criteria are guidelines; they supplement, not replace, clinical judgment
- No change to medical necessity criteria

Service:

Medical Necessity Criteria:

Psychiatric Inpatient

InterQual

Level A, B, and C Residential

DMAS and InterQual

CMHRS Services

DMAS

Outpatient Psychiatric and

DMAS and InterQual

Substance Abuse

How to Request Service Authorizations

- Inpatient Psychiatric Hospitalization: Web and phone
- CMHR Services and Level A, B, and C Residential: Web and Fax or by phone/certified mail
- Outpatient psychiatric and Substance Abuse: Web and Fax or certified mail
- **Care Managers are available to assist**

Service Request Application(SRA)

- SRA used for CMHR service requests and Level A, B,C Residential
- SRA incorporates all the DMAS-required information elements for submission(and InterQual when required)
- Allows for direct data entry when submitted online
- May download SRA and fax or send by certified mail
- CANS, CON or Rate Reimbursement Certificate are submitted as has been done in the past

Role of Care Manager and Physician Advisor

- **Care Manager(CM):**
 - Crisis Triage
 - Referral
 - Service Authorization
 - Quality
 - Care Coordination
 - Discharge and Transition Planning
- **Physician Advisor(PA)**
 - Non-authorization and Reconsideration
 - Consultation

Care Coordination

Care management coordination of care for members

Ambulatory follow-up and discharge planning for all members in inpatient and/or residential settings under our management

Coordination of care with the MCOs and PCPs

MCO liaison will work with MCOs to develop strategies for identification of members with co-morbid mental health and medical needs, and facilitate referrals into respective systems of care

Implementation of initiatives to improve the coordination of care between PCPs and behavioral health providers: PCP toolkit, PCP consult line, and PCP training program

Quality Improvement: Provider Voice and Participation in Committees

Magellan is committed to promoting stakeholder voice in the design and development of our quality program. Design and development occur primarily through our QI committee structure. As stakeholders, providers are invited to participate in all QI committees.

Quality Improvement Committees:

- Quality Improvement Committee(oversight committee)
- Utilization Management Committee
- Member Services Committee
- Regional Network Credentialing Committee
- Network Strategy Committee
- Family, Member, Stakeholder Advisory Committee

QI: Clinical Practice Guidelines(CPSs)

Magellan adopts CPGs based on sound scientific evidence, clinical best practices and member needs. Magellan requires all of its providers to be familiar with these CPGs. CPGs are available through the website.

Magellan Adopted Clinical Practice Guidelines

- **Acute Stress Disorder & Post-Traumatic Stress Disorder**
- **ADHD**
- **Autism**
- **Bipolar Disorder**
- **Depression**
- **Eating Disorders**
- **Generalized Anxiety Disorder**
- **Managing Suicidal Patients**
- **Obesity**
- **Obsessive-Compulsive Disorder**
- **Schizophrenia**

QI: Provider Grievance

Magellan believes that provider input concerning our programs and services is a vital component of our quality program.

Provider complaints, comments and compliments:

- Can be submitted through the Magellan provider website.
- Can be submitted by contacting the Virginia Care Management Center

The cooperation and assistance is expected from providers during the investigation of member grievance, adverse incidents and quality of care concerns.

Reconsiderations and Appeals

- **Adverse Determination:** An admission, availability of care, continued stay or other health care service that has been reviewed by a physician advisor and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the request for service is denied, reduced, suspended, delayed or terminated.
- **Adverse Action:** Any decision by a PA to deny a service authorization request or to not authorize a service in an amount, duration or scope as requested.
- **Reconsideration:** A request for a second review by a Magellan PA, different from the first PA, to review the adverse action. **Providers must request a reconsideration before filing an appeal with DMAS**
- **Appeal:** A formal request to DMAS to review the Magellan determination of the reconsideration.

Questions

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